DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 9/16/12

PRINTED: 08/09/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445237	A. BUILDING _____ B. WING _____	08/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH HILL CARE & REHAB CTR	701 WEST MAIN BLVD CHURCH HILL, TN 37642

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes:	F 156	1. Resident #76 responsible party was notified by the Social Services Director on 8/2/2012 of insufficient time frame for notification of completion of skilled services. The Administrator in-serviced the Social Services Director regarding the proper notification on 8/2/2012. All residents identified to be nearing completion of skilled services will be issued NOMNC no less than 2 days prior to completion of skilled services. 2. Audit of all residents that have completed skilled services and issued a NOMNC in the past 30 days have been completed as of 8/ 13/12 by the Social Services Director and no other residents were found to be deficient. 3. The Social Services Director in-serviced the Social Services Assistant, MDS staff and therapy manager on the NOMNC process on 8/9/2012 using the regulation from CMS related to NOMNC procedure for issuance and appropriate time frame for last date of skilled services.	8/23/2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: JoAnna Eddy, RN Administrator — TITLE: — (X6) DATE: 8/17/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 156	Continued From page 1 A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This	F 156	4. A weekly audit will be completed 4 times a week times 4 weeks. Monthly audits will be completed 4 times a month for 2 months and submitted for review and all issues will be identified and corrected. Weekly reviews will be completed during PPS meetings. The results of this audit will be reviewed and discussed in monthly Quality Assurance Performance Improvement meetings comprised of the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Coordinator, Minimum Data Set Nurse, Nurse Educator, Dietary Manager, Activity Director, Plant Operations Manager and Environmental Director.	

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F 156	Continued From page 2 includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on review of financial records and interview, the facility failed to provide timely Notice of Medicare Non-Coverage to one (#76) of five resident records reviewed. The findings included: Review of resident financial records revealed a Social Service note dated July 30, 2012, "Medicare skilled services will end 7/31. Spoke with res. (resident's)...adult child)...and explained NOMNC (Notice of Medicare Non-Coverage) and the completion of skilled care...(adult child) verbalized understanding and will be..." Interview with the Social Service Director on August 2, 2012, at 8:35 a.m., in the business office, confirmed the facility failed to give at least two full days notice and the Notice of Medicare	F 156		

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F 156	Continued From page 3 Non-Coverage was not completed timely.	F 156		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to perform a complete assessment for one (#168) of two residents reviewed with pressure ulcers of thirty-two residents with assessments reviewed in Stage 2. The findings included: Resident #168 was admitted to the facility July 11, 2012, with diagnoses including C1-C4 Fracture, CL (Cord Injury), Cervicalgia (neck pain), Central Hearing Loss, Hypertension, Esophageal reflux, Osteoarthritis, and History of Falls. Medical record review of the care plan dated July 11, 2012, revealed "...to minimize pressure on bony prominences...Keep clean and dry...July 20, 2012, noted...impaired skin integrity...July 31, 2012, skin assessment per policy...Note changes in level of risk for skin breakdown..."	F 314	1.Res #168 has been assessed by the wound care nurse to ensure all skin problems are documented accurately on 08/02/2012. Resident #168 had no adverse reaction noted. 2. A 100% audit of all skin assessment for all residents was completed by the Director of Nursing on 08/12/2012 for the past 30 days. All residents noted to have completed skin assessments with appropriate treatments in place. No adverse outcomes noted. 3.All licensed nurses will be in serviced by the Nurse Educator on completing skin assessments upon admission. In services began on 08/02/2012and will be completed by 08/23/2012. The wound care nurse will review all admissions to ensure a skin assessment has been completed and follow up with any skin issues noted. 4. The Wound Care Nurse will audit 10 skin assessments a week for 4 weeks then 10 a skin assessments a month for 2 months and/ or until 100% compliance is noted. The wound care nurse will report the findings at the monthly Quality Assurance Meeting comprising of the Medical Director, Administrator, Director of Nursing, Asst Director of Nursing, Nurse Educator, Medical Records Director, Rehab Manager, Social Service Coordinator, Minimum Data Set Nurse, Dietary manager, Activity Director, Maintenance Supervisor and Environmental Director.	8/23/2012

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F 314	Continued From page 4	F 314		

Medical record review of the admission skin assessment on July 11, 2012, at 10:25 p.m., revealed an open area the size of a quarter on the thoracic spine with a dressing intact from the hospital.

Medical record review of the weekly skin assessment completed on July 16, 2012, at 3:55 p.m., revealed, "...abrasions to lower back and monitor for possible breakdown/irritation..."

Medical record review of the wound care nurses notes completed on July 17, 2012 revealed, "...abrasion noted to mid upper back (noted on admission)...2.5 cm (centimeters) x (by) 2 cm x < (less than) 1/8 cm...100% reddened abrasion with 1 cm of peri-wound redness noted...No odor no bogginess noted to peri-wound...Continue with treatment as ordered."

Medical record review of physician's orders revealed an order dated July 12, 2012, "...Check transparent dressing on open area on back daily (till healed) and apply allevyn dressing to boney prominence on back and monitor until healed..." and, July 13, 2012, "...Apply allevyn dressing to boney prominence on back every other day for protection and monitor dressing to back daily AM and PM..."

Interview with the wound care nurse on August 1, 2012, at 11:09 a.m., in the wound care nurse's office, confirmed the wound originally appeared as an abrasion but a follow-up examination completed by the wound care nurse on July 23, 2012, revealed the wound abrasion was actually an unstageable pressure area and the admission

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F 314	Continued From page 5 nurse failed to remove the dressing and perform a complete assessment including size and description of the wound.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, and staff interview, the facility failed to complete a bladder assessment and develop an individualized toileting plan for one (#125) of three residents with a decline in continence since admission of thirty-two residents reviewed in Stage 2. The findings included: Medical record review revealed resident #125 was admitted to the facility on April 9, 2012, with diagnoses including Late Effect Cerebrovascular Disease, Aphasia, Muscle Weakness, Osteoporosis, Hypertension, and Vascular Dementia with Depression. Medical record review of the Admission Minimum	F 315	1. Resident #125 had urinary assessment completed by the RN Supervisor on 08/02/2012. Resident #125 has been placed on an individualized toileting program which began on 08/14/2012 for urinary incontinence. 2. A 100% audit on all residents was completed by the Director of Nursing and Nurse Supervisor for any declines in urinary continence and urinary assessments completed to determine the need for individualized toileting programs competed 08/09/2012 - 08/16/2012. No residents noted to be affected. 3. Nursing staff in serviced by the Nurse Educator on completing urinary assessments on all admissions which started on 08/02/2012 and will be completed by 08/23/2012. 4. The Minimum Data Set Nurse will audit all admissions and all residents quarterly for 3 months and/ or 100% compliance. The Minimum Data Set Nurse will report findings at the monthly Quality Assurance meeting comprising of the Medical Director, Administrator, Director of Nursing, Asst Director of Nursing, Nurse Educator, Medical Records Director, Rehab Manager, Social Service Coordinator, Minimum Data Set Nurse, Dietary manager, Activity Director, Maintenance Supervisor and Environmental Director.	8/23/2012

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F 315	Continued From page 6 Data Set (MDS) dated April 15, 2012, revealed the resident was frequently incontinent of bladder and was moderately impaired cognitively. Medical record review of the Quarterly MDS dated July 15, 2012, revealed the resident was always incontinent of the bladder and remained moderately cognitively impaired. Medical record review of the nurse charting for Urinary Continence Assessment revealed no bladder assessment. Review of facility policy, Continence Care, revealed "Bladder Management 1. Policy It is the policy of this facility to ensure each resident who is incontinent of bladder is identified and assessed, given the opportunity to achieve continence or to restore as much normal bladder function as is possible. Appropriate treatment and services will be provided to restore as much function as possible." Interview with the Assistant Director of Nursing (ADON) on August 2, 2012, in the ADON's office at 8:42 a.m. and 11:15 a.m., confirm there was no urinary continence assessment upon admission. Further interview revealed urinary continence assessments were also to be performed quarterly and confirmed no assessment was completed for July 2012. Further interview confirmed there was no policy for the Incontinent Management Program or the Bladder Rehabilitation Program as outlined in the Continence Care policy.	F 315		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of	F 332		

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F 332	Continued From page 7 medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and interview, the facility failed to maintain a medication error rate of less than five percent for three errors of fifty-five, resulting in a 5% medication error rate for three (#77, #94, and #37) of ten residents and three of five nurses observed. The findings included: Observation of Licensed Practical Nurse (LPN) #2 during a medication pass on August 1, 2012, at 8:01 a.m., on B wing, revealed LPN #2 placed medications for resident #77, including one Enteric Coated Aspirin 325 mg (milligrams), in a plastic pouch, crushed all of the medications, including the Enteric Coated Aspirin, mixed the crushed medications in pudding, and administered the medications to the resident, in the resident's room. Medical record review of physician's orders revealed an order dated May 1, 2012, for Aspirin Enteric Coated 325 mg Delayed Release, daily by mouth. Interview with LPN #2 on August 1, 2012, at 8:08 a.m., on B wing, revealed, "...It's 325 enteric coated. Sometimes we have to (crush the medication) for (resident) because (resident) won't take it." Further interview confirmed the LPN was aware enteric coated medications were	F 332	1. Residents #77 was assessed for adverse reaction by the Director of Nursing on 08/02/2012 and MD notified of medication error. No new orders received and no adverse reactions noted. Nurse #2 was in serviced by the Nurse Educator to not crush Enteric Coated aspirin on 08/02/2012 Residents #37 was assessed for adverse reaction by the Director of Nursing on 08/05/2012 and MD notified of medication error. No new orders received and no adverse reactions noted. Nurse # 1 was in serviced on 08/05/2012 regarding proper administration of inhalers. Residents #94 was assessed for adverse reaction by the Director of Nursing on 08/05/2012 and MD notified of medication error. No new orders received and no adverse reactions noted. Nurse #3 was in serviced by the Nurse Educator on 08/05/2012 to not crush Potassium Chloride. 2. All licensed nurses were in serviced on medication administration by the Nurse Educator which started on 08/05/2012 and will be completed by 08/23/2012. The Nurse Management team which consists of the Director of Nursing, the Assistant Director of Nursing, the Nurse Educator, the Minimum Data Set nurse and the Skilled Care Coordinator started medication observation on 08/10/2012 to be completed by August 23 2012 for all licensed nurses.	8/23/2012

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F 332	Continued From page 8 not to be crushed. Observation of LPN #3 during a medication pass on August 1, 2012, at 8:24 a.m., on C wing, revealed LPN #3 placed medications for resident #94, including Potassium Chloride 20 meq (milliequivalents), in a plastic pouch, crushed all of the medications, including the Potassium Chloride, placed the crushed medications in applesauce, and administered the medications to the resident in the resident's room. Medical record review of the physician's orders revealed an order dated June 3, 2012, for Potassium Chloride Crystals Controlled Release 20 meq extended release by mouth daily. Observation and interview with LPN #3 on August 1, 2012, at 8:35 a.m., on C wing, confirmed the box of Potassium Chloride was labeled "Do Not Crush" and the medication had been crushed. Observation on August 1, 2012, at 8:21 a.m., during medication pass, on the C Wing, revealed LPN #1, administered Combivent inhaler to resident #37. Observation revealed LPN #1 administered the one puff of the inhaler and failed to wait one minute between the administration of the second puff. Review of the physicians recapitulation orders dated July 1, 2012 to July 31, 2012, revealed a physicians order for Combivent 18 mcg (micrograms)/act (per activation) -103mcg/act aerosol inhalation puffs (wait 1 minute between puffs) two times day. Interview with LPN #1 on August 1, 2012, at 8:30	F 332	3. All new hires will go through a medication administration training with the Nurse Educator during the new hire orientation process and will be observed on medication administration with a 0% error rate prior to completion of their orientation. 4.The Nurse Educator will observe med pass administration for 10 residents a week for 4 weeks then 10 residents a month for 2 months and/ or until 100% compliance is noted. The Nurse Educator will report all findings at the monthly Quality Assurance meeting comprising of the Medical Director, Administrator, Director of Nursing, Asst Director of Nursing , Nurse Educator, Medical Records Director, Rehab Manager, Social Service Coordinator, Minimum Data Set Nurse, Dietary manager, Activity Director, Maintenance Supervisor and Environmental Director.	

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F 332	Continued From page 9 a.m., in the hallway outside the residents' room, confirmed the nurse administered one puff of the Combivent inhaler and failed to wait one minute between the first and second puff of the inhaler.	F 332		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility dietary department failed to maintain sanitary conditions for equipment and storage areas. The findings included: Observation of the facility resident breakfast tray line on August 1, 2012 at 7:45 a.m., revealed the cook obtaining food temperatures without sanitizing the thermometer between food items. Observation on August 1, 2012, beginning at 8:05 a.m., with the dietary manager present, revealed the following: 1.) Observation a plastic covered slicer revealed the dietary manager uncovered the slicer to reveal dried debris attached to the food holder prongs.	F 371	1. The food slicer was cleaned on 8/1/2012. The Dietary Manager was in-serviced by the Administrator on cleaning of kitchen equipment 2. The Dietary Manager inspected all kitchen equipment for cleanliness. All other kitchen equipment was clean.. 3. The Dietary Manager began in-servicing staff on proper cleaning of the kitchen area on 8/1/2012 and will be completed by 8/23/2012. Any new dietary staff will be in-serviced upon orientation. 4. The kitchen equipment will be audited by the Dietary Manger 5 x a week for 2 weeks and then 3 x week for 4 weeks and then monthly x 2. All findings will be reported at the monthly Quality Assurance meetings comprised of the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Coordinator, Minimum Data Set Nurse, Nurse Educator, Dietary Manager, Activity Director, Plant Operations Manager, Medical Records Director, Environmental Director, and Rehab Manager.	8/23/2012

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F 371	Continued From page 10 2.) A shelf over the utensil hanging rack had a layer of dried debris. Further observation revealed two plastic storage containers, with the open end in contact with the surface of the shelf, were stored on the shelf. 3.) Two dish racks were in contact with the dish room floor. 4.) The walk-in refrigerator had debris hanging from the ceiling in front of the operational condenser fans and debris was on the operational condenser fan grates. The refrigerator contained uncovered onions in a bag. 5.) The walk-in freezer operational condenser fan grates had an accumulation of dried debris. Interview with the cook on August 1, 2012, at 7:45 a.m., confirmed the cook did not sanitize the thermometer between food items. Interview with the dietary manager, present during the observations on August 1, 2012, beginning at 8:05 a.m., revealed the cover on the slicer indicated the slicer was clean and ready to use. Further interview confirmed there were dried debris attached to the slicer food holder prongs. Further interview confirmed the shelf, containing the plastic storage containers, had a layer of dried debris. Further interview confirmed there were two dish racks stored on the dish room floor; the walk-in refrigerator and walk-in freezer operational condenser fan grates had an accumulation of debris; and the walk-in refrigerator had debris hanging from the ceiling in front of the operational condenser fans with uncovered onions stored in the refrigerator.	F 371	1. The shelf over the utensil hanging rack was cleaned and the storage containers properly closed on 8/1/2012. The Administrator in-serviced the Dietary Manager on cleaning the shelves. 2. The Dietary Manager inspected all shelves for cleanliness. All other shelves were clean. 3. In-servicing was started by the Dietary Manager on the proper cleaning of the shelves on 8/1/2012 and will be completed by 8/23/2012. Any new dietary staff will be in-serviced upon orientation. 4. The shelves in the kitchen will be audited by the Dietary Manager 5 x a week for 2 weeks and then 3 x week for 4 weeks and then monthly x 2. All findings will be reported by the Dietary Manager at the monthly Quality Assurance Performance Improvement meeting comprised of the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Coordinator, Minimum Data Set Nurse, Nurse Educator, Dietary Manager, Activity Director, Plant Operations Manager, Medical Records Director, Environmental Director, and Rehab Manager.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445237	A. BUILDING _____ B. WING _____	08/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH HILL CARE & REHAB CTR	701 WEST MAIN BLVD CHURCH HILL, TN 37642

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F 441	Continued From page 11 The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced	F 441	F 371 con't 1.The dish racks were removed from off of the floor on 8/1/2012. The Dietary Manager was in-serviced by the Administrator. 2.The Dietary Manager inspected the dish room for anymore dish racks on the kitchen floor and none were found. 3. The Dietary Manager began in-servicing the dietary staff on the proper storage of the dish racks on 8/1/2012 and will be completed by 8/23/2012. Any new dietary staff members will be in-serviced upon orientation. 4.The Dietary Manager will audit the dish room for any dish racks on the floor 5 x week for 2 weeks and then 3 x week for 4 weeks and then monthly x 2. All findings will be reported at the monthly Quality Assurance Performance Improvement meeting comprised of the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Coordinator, Minimum Data Set Nurse, Nurse Educator, Dietary Manager, Activity Director, Plant Operations Manager, Medical Records Director, Environmental Director, and Rehab Manager.	

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F 441	Continued From page 12 by: Based on medical record review, observation, interview, and review of manufacturer's instructions, the facility failed to follow infection control practices during incontinence care for one of three residents observed for incontinence care and during a dressing change for one of two residents observed with pressure ulcers; and failed to follow manufacturer's instructions for disinfecting the glucometer for one of four medication carts. The findings included: Resident #84 was readmitted to the facility on May 30, 2012, with diagnoses including Anemia, Atrial Fibrillation, Coronary Artery Disease, Deep Vein Thrombosis, Congestive Heart Failure and Hypertension. Medical record review of the Minimum Data Set (MDS), dated May 30, 2012, revealed the resident scored a five on the Brief Interview for Mental Status (BIMS) indicating the resident was severely cognitively impaired. Further review of the MDS revealed the resident required extensive assistance with toileting. Observation on August 1, 2012, at 12:30 p. m., in the residents room, revealed during incontinence care, Registered Nurse (RN) #1 donned clean gloves and wiped the stool and urine. Continued observation revealed the nurse turned to throw the soiled brief in the trash can, leaned over the residents opened food tray with the soiled brief and wash cloth and discarded the soiled brief in the trash can.	F 441	F 371 con't 1. The debris was cleaned off of the walk-in refrigerator condenser fan grate and the onions were placed in a covered container on 8/1/2012. The Dietary Manager was in-serviced by the Administrator on keeping the fan grate clean and on the proper storage of food. 2. The Dietary Manager inspected the refrigerator for cleanliness and proper food storage. 3. The dietary staff has been in-serviced by the Dietary Manager on keeping the condenser fan grate clean and the proper storage of food beginning on 8/1/2012 and will be completed by 8/23/2012. Any new dietary staff will be in-serviced upon orientation. 4. The walk-in refrigerator fan grate and proper storage of food will be inspected by the dietary manager 5 x week for 2 weeks and then 3 x week for 4 weeks and then monthly x 2. All findings will be reported by the Dietary Manager at the monthly Quality Assurance Performance Improvement meeting comprised of the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Coordinator, Minimum Data Set Nurse, Nurse Educator, Dietary Manager, Activity Director, Plant Operations Manager, Medical Records Director, Environmental Director, and Rehab Manager.	

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F 441	Continued From page 13 Interview with RN #1 on August 1, 2012, at 12:45 p.m., outside of the resident's room, confirmed the nurse leaned over the residents open food tray with the soiled linen and the soiled brief. Observation of a wound dressing change for resident #50, with RN #1, on August 2, 2012, from 9:06 to 9:32 a.m., in the resident's room, revealed the resident had the following three wounds to the right foot: the heel was a dry, healing wound, measuring 0.2 cm (centimeters) x (by) 3 cm; the outer foot, an open wound measuring 1.3 cm x 0.7 cm; and the inner ankle, an open wound measuring 4 cm x 5 cm with 80% slough (slough is necrotic/avascular tissue in the process of separating from the viable portions of the body & is usually light colored, soft, moist, & stringy at times) and the outer area of the wound was red and inflamed. Continued observation revealed RN #1 sprayed a wound cleanser on the three wounds using a spray bottle with a trigger handle and a mirror placed under the right foot to visualize the wounds. Continued observation revealed the wound cleanser dripped from the resident's right foot onto the mirror underneath the resident's foot. Continued observation revealed, following the wound care, the wound cleanser bottle and mirror were placed in the bottom drawer of the treatment cart, without sanitizing the wound cleanser bottle or the mirror. Interview with RN #1 on August 2, 2012, at 9:32 a.m., on B wing, confirmed the bottle and mirror were taken to multiple residents' rooms to be used during wound care and had not been sanitized before replacing in the treatment cart. Observation of a medication pass on August 1,	F 441	F 371 con't 1. The debris was cleaned off of the walk-in freezer condenser fan grate on 8/1/2012. The Administrator in-serviced the Dietary Manager on keeping the fan grate clean. 2. The Dietary Manager inspected the rest of the walk-in freezer for cleanliness and no other debris was found. 3. The dietary staff was in-serviced by the Dietary Manager on keeping the condenser fan grate clean on 8/1/2012 and will be completed by 8/23/2012. Any new dietary staff will be in-serviced upon orientation. 4. The walk-in freezer will be audited by the Dietary Manager 5 x week for 2 weeks and then 3 x week for 4 weeks and then monthly x 2. All findings will be reported by the Dietary Manager at the monthly Quality Assurance Performance Improvement meeting comprised of the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Coordinator, Minimum Data Set Nurse, Nurse Educator, Dietary Manager, Activity Director, Plant Operations Manager, Medical Records Director, Environmental Director, and Rehab Manager.	

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F 441	Continued From page 14 2012, at 4:41 p.m., on D wing, revealed Licensed Practical Nurse (LPN) #1 was preparing to check the blood sugar of resident #26, with a glucometer from the medication cart. Continued observation revealed LPN #1 wiped the glucometer with a single-use disinfectant wipe by wiping the glucometer completely over in approximately 20 seconds, placing the glucometer on a pair of gloves, and carrying the gloves and glucometer into the resident's room. Continued observation revealed, approximately three minutes after entering the resident's room, LPN #1 checked the resident's blood sugar utilizing the glucometer, left the room, and using another disinfectant wipe, cleaned the glucometer in approximately 30 seconds and replaced it in the top drawer of the medication cart. Review of the manufacturer's instructions on the package of the disinfectant wipe revealed, "...Unfold a clean wipe and thoroughly wet surface. Treated surface must remain visibly wet for a full two (2) minutes. Use additional wipe(s) if needed to assure continuous two (2) minute wet contact time. Let air dry..." Interview with LPN #1 on August 1, 2012, at 4:50 p.m., on D wing, confirmed the glucometer was used on multiple residents and the LPN thought a wait time of two minutes after cleaning the glucometer was required, but was not aware the manufacturer instructions were for the glucometer to stay visibly wet for two minutes. Interview with the Infection Control Coordinator on August 2, 2012, at 1:40 p.m., in the conference room, confirmed the glucometers were to be wet for two minutes, and the	F 441	F 371 con't 1. The cook was in-serviced by the Dietary Manager on the proper sanitation of thermometers between food items on 8/1/2012. 2. The Dietary Manager began in-servicing all dietary staff on the proper sanitation of thermometers between taking temps of different food items on 8/1/2012 and will be completed by 8/23/2012. 3. The Dietary Manager will conduct weekly in-services with the dietary staff and any new staff on the proper way to sanitize the thermometers when checking food temps between different food items. 4. An audit will be conducted by the Dietary Manager 5 x week for 2 weeks then 3 x week for 4 weeks then monthly x 2 on properly sanitizing the thermometers between food items. All findings will be reported at the monthly Quality Assurance Performance Improvement meeting comprised of the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Coordinator, Minimum Data Set Nurse, Nurse Educator, Dietary Manager, Activity Director, Plant Operations Manager, Medical Records Director, Environmental Director, and Rehab Manager.	

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F 441	Continued From page 15 manufacturer's instructions for cleaning and disinfecting the glucometers had not been followed.	F 441	1. The nurse provided resident # 84 with a new food tray on 08/01/2012.Res #84 assessed by the Director of Nursing on 08/01/2012 and no adverse outcomes noted. RN #1 was in serviced by the Nurse Educator on properly disposing dirty linens and soiled briefs to prevent cross contamination on 08/01/2012. RN #1 cleaned the treatment cart and equipment on 08/02/2012. RN #1 was in serviced by the Nurse Educator on 08/02/2012 regarding proper cleaning equipment prior to placing items back on the treatment carts. No adverse outcomes noted. Resident #26 was assessed by the Director of Nursing on 08/02/2012 and no adverse outcomes noted. LPN # 1 was in serviced by the Nurse Educator on 08/01/2012 on proper cleaning of the glucometer and return demonstration provided with the Nurse Educator. LPN #1 cleaned glucometer according to manufacturer recommendations on 08/02/2012 . 2. In service provided to nursing staff on proper disposal of linens/ briefs provided by the Nurses Educator on 08/02/2012. No residents noted to be affected by deficient practice. Both treatment carts and all equipment were cleaned and disinfected by the wound care nurse on 08/01/2012. No residents noted to be affected. Glucometers on all halls were cleaned by licensed nurse on 08/02/2012. No residents noted to be affected.	8/23/2012

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Division of Health Care Facilities

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	TN3701	A. BUILDING _____ B. WING _____	08/02/2012

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N 000	Initial Comments During the annual Licensure survey conducted on July 30, 2012 through August 02, 2012, at Church Hill Health Care and Rehabilitation Center, no deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes.	N 000	F 441 con't 3. The Nurse Educator is in servicing all licensed and certified staff on proper disposal of dirty linens and briefs during peri care. All nursing staff will be required to attend in service provided by the Nurse Educator and/ or the Director of Nursing by 08/23/2012. . During new hire orientation nursing staff will be in serviced by the Nurse Educator on proper disposal of soiled linens and briefs during peri care. The Nurse Educator is in servicing nurses regarding cleaning and disinfecting equipment prior to placed items back in the treatment cart. Both treatment carts and all equipment were cleaned and disinfected on 08/02/2012 by the wound care nurse All nurses will be required to attend in service by the Nurse Educator and/ or the Director of Nursing by 08/23/2012. In services began on 08/02/2012. During new hire orientation all nurses will be in serviced by the Nurse Educator on cleaning and disinfecting equipment prior to placing items back on the treatment cart All nurses to be in serviced on proper cleaning of the glucometers by the Nurse Educator began on 08/02/2012 and will be completed by 08/23/2012. During new hire orientation all nurses will be in serviced by the Nurse Educator on cleaning of glucometers 4. The Assistant Director of Nursing and/ or the Director of Nursing will complete audits on disposal of briefs and linens during peri care 10 times a week x 4 weeks and 10 times a month for 2 months and/ or until 100% compliance is met. All findings will be reported at the monthly Quality Assurance meeting comprising of the Medical Director, Administrator, Director of Nursing, Asst	

Division of Health Care Facilities

Donna Eddy, RN Administrator — TITLE — 8/17/12 (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE